tracted the sting, but no means which he afterwards used were capable of subduing the morbid excitement of the organ. When Dr. Kreig saw the patient the conjunctiva was greatly hypertrophied and the cornea covered with a dense opaque layer of membrane. There was every reason to believe that the internal structures, also, fully participated in the diseased process. On closely examining the eye with a magnifying glass, a dark and slightly prominent spot was discovered in the centre of the cornea, around which much vascular injection was perceptible, and from this spot Dr. Kreig extracted a long filiform body, the remaining part of the sting. The inflammation soon began to subside, and in a month the cornea had partially recovered its transparency, but some striking results became permanent in consequence of the injury. The tint of the iris had changed from its natural grayish blue to a perfect blue, the pupil remained dilated and immovable on the stimulus of light, and the patient, who before his accident was obliged to use convex glasses, now required one concave, being near-sighted, on the left side.—*Gaz. des Hôpitaux*, 27th June, 1843, from *Casper's Wochenschrift.*

MIDWIFERY.

42. *Bilocular Uterus and cleft Vagina.*—A woman 30 years of age, pregnant, applied for admission into a lying-in charity in Vienna. Externally she was well-shaped and appeared robust; but on making examination, the vagina, at the depth of about two inches, was found divided into a double passage by a dense fibrous septum stretching across it. The posterior chamber was penetrable by the finger for about an inch and a half higher, when it was found to end in a small blind sac. The anterior passage of the vagina was so long that the os uteri could not be reached by the finger; the fœtus accordingly lay very high in the pelvis. The birth was at first lingering, but in the progress of the labour the septum in the vagina spontaneously ruptured, with little loss of blood; the liquor amnii was immediately discharged, and in a short time afterwards a living child was safely expelled. The mother, however, died of peritonitis four days afterwards, and on opening the body the cavity of the uterus, as far as the os internum, was seen to be separated into two chambers by a vertical septum. The fœtus had lodged in the left of these divisions, but the right cavity had also been dilated and lined with decidua during the pregnancy.—*Lancet*, Nov. 11, 1843, from *Oest. Wochensch.* Sept. 9.

43. *Vaginal pregnancy.*—One of the German journals reports a case of extra-uterine gestation in which the fœtus was developed in the vagina. A circumscribed enlargement was apparent between the navel and the pubis, and the bowels and bladder were evacuated with much difficulty. A practitioner appears to have been first called in at about the fourth month (die Gehurt schon bis zur *vierten period* vorg. war), who found the fœtus in a cross position and dead. He immediately proceeded to delivery by the feet, and after much difficulty brought the shoulders through the vulva, and afterwards extracted the head with the forceps. The circumscribed tumour was yet unreduced, and on examination this was found to be due to the uterus itself. That organ was retroverted, its orifice being directed forwards to the abdominal integuments, and closely embracing the cord. The accoucheur contrived, however, to introduce some of his fingers within the os tincæ and remove the placenta, which is said to have been adherent to the neck, and, indeed, to all the rest of the internal surface of the uterus. The woman recovered satisfactorily. We know of only one other recorded case of this very rare kind of extra-uterine gestation; it is detailed in the "Journ. de Med.," &c., of Paris, 1779. The latter case terminated unfavourably to the mother.—*Ibid.*

44. *Polypus Uteri.*—Dr. P. Murphy, of Liverpool, in an article in the *Provincial Med. Journal*, (Sept. 23, 1843,) states that he has treated seven cases of

polypus uteri; the termination of all which were favourable except one. "In each case the woman was married, had n family, and had not ceased to menstruate. The symptoms were similar—namely, hæmorrhage, and leucorrhœa, producing anæmia. The discharge, unless retained by the size of the tumour, was not *fœtid;* and this need not excite surprise, as the surface of the polypus is similar to that of the lining membrane of the uterus.

"If a female, after having ceased to menstruate for four or five years, is then attacked with a discharge of mucous blood or pus from the vagina, it may be regarded almost as a fatal symptom. Even if, on examination, the os tincæ be found perfectly healthy, the diagnosis must be guarded; for I have notes of three cases in which, after death, the discharge was traced to ulcerated cancer of the intestines opening into the body of the uterus. Polypus is sometimes a cause of premature delivery. A gentleman sent for me to aid him in checking hæmorrhage after such a case. The placenta was retained, and, as he imagined, adherent; the polypus and placenta were partly in the vagina; there was some difficulty in suppressing the hæmorrhage; and I heard afterwards that she was successfully operated on in Manchester. The removal of a polypus is attended with very little danger or difficulty. If small, it is soft and vascular, its shape is nearly circular, and the ligature does not hold on well, and if excised, there is the risk of hæmorrhage. This is dangerous, for the slightest *sudden* loss of blood from an operation cannot be well borne, as the woman is anasarcous and exhausted before she submits. However, this may be easily guarded against by filling the vagina with lint or tow, and if torsion be previously practised, the security is increased. The advantages of excision are—its facility, its speediness, its sparing both the patient and the operator the disagreeable task of tightening the ligature daily, its confining the sufferer a shorter time in bed, but, above all, its not being attended with that fœtor which contaminates the bed-chamber, and exposes her to an attack of low fever, similar to that generated from the non-ventilation of the lying-in chamber, and which is the unavoidable consequence of the ligature.

"When the polypus is very large the ligature must be employed, as it is impossible to reach the pedicle either with the knife or the scissors, nor can we draw it through the os externum. The surrounding it with a ligature is not difficult, for I readily succeeded, but its removal when detached is troublesome. Dr. Gooch mentions one or two cases where uterine pains came on, and assisted the expulsion, and in another he succeeded with his hand.

"A tenaculum is not sufficiently strong, and moreover, sharp pointed instruments should be avoided. On the other hand, it is very difficult to fix the tumour longitudinally in a forceps."

"After the operation the diet," Dr. M. says, "should not be lessened; on the contrary, we cannot too soon commence a tonic treatment."

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45. *Inflammation and Abscess of the Uterine Appendages.—The Dublin Journal of Medical Science*, for September last, contains an exceedingly interesting paper on this subject, by Dr. Fleetwood Churchill. Dr. C. relates twenty-three cases of this disease, some occurring in his own practice, and others collected from various sources, and deduces from them the following practical inferences:

1. Inflammation of the uterine appendages may occur in an acute or chronic form. In the former, it constitutes one of the varieties of puerperal fever, and has been most ably treated by Clarke, Lee, Fergusson, Puzos, Husson, Dance, Tonnellé, &c. The latter author found fifty-eight cases of ovarian inflammation and four of abscess, in 190 cases of puerperal fever. Dr. Lee states, that in one case the ovary "appeared to be converted into a large cyst containing pus, which had contracted adhesions with the abdominal parietes, and discharged its contents externally through an ulcerated opening. In another case, which proved fatal, the inflamed uterine appendages agglutinated together, had contracted adhesions with the peritoneum at the brim of the pelvis, the inflammation having extended to the cellular membrane exterior to the peritoneum, and

occasioned an extensive collection of pus in the course of the psoas and iliacus externus muscles, similar to what takes place in lumbar abscess."*

As to the symptoms of this acute disease, Dr. Lee briefly remarks,—"The pain is generally less acute than in peritonitis, and is principally seated in one or other of the iliac fossæ, extending from them to the loins, anus, and thighs. On pressure, the morbid sensibility will be found to exist chiefly in the lateral parts of the hypogastrium. The constitutional symptoms at the commencement of the attack do not materially differ from those which mark the accession of peritonitis, being often accompanied with strong febrile action, which speedily subsides, and is suddenly followed by prostration of strength and other changes, which characterize inflammation of the muscular and mucous tissues of the uterus." Dr. Lee details eight cases of the disease which proved fatal.

It is not my object to enter further upon the consideration of the acute form of the affection, but immediately to proceed to notice the *chronic disease*.

It has been described, as I have said, by several authors under different names. Puzos calls these abscesses "depôts du lait," or "depôt laiteux dans l'hypogastre;" and Levret, "engourdissemens laiteux dans le Bassin;" from an erroneous supposition that they were caused by metastasis of the milk to these parts.

The disease described by Dr. Doherty is essentially the same as the one under consideration, but occurring in general at an earlier period after delivery; differing very little in symptoms, but terminating more favourably, that is, in resolution. It appears altogether a simpler affection, quicker in its course, and much more manageable under similar treatment.

2. Chronic inflammation of the uterine appendages may occur, though rarely, independently of pregnancy or labour, but far more frequently after labour, and at varying intervals: the first intimations being perceived in some cases from three to ten days after delivery, and in others not until the lapse of some weeks.

3. *Causes.*—It is very difficult to assign any special *cause* for the attack. It may follow blows, falls, or a fright; or more frequently result from cold.

From the coincident suppression of the milk or the lochia† it is sometimes attributed to either accident.

That it may occur in consequence of the long-continued pressure of the child's head in lingering labour I do not doubt, but it is evident that this is not a frequent cause, as most of the cases occurred after natural labour.

Lastly, it may be the termination of acute inflammation.

4. *Invasion.*—The mode of invasion varies a good deal.

a. In certain cases there are few, if any, preliminary symptoms; uneasiness perhaps, but not amounting to pain, in one iliac region, and upon placing her hand on the spot, the patient detects a tumour.

b. Or, after a favourable convalescence for some days, just as the usual term of our attendance expires, the patient experiences a slight febrile attack, with some shooting pains in the abdomen, which subside after a time, though the fever remains without any apparent cause, until, in the course of time, the disease is developed.

c. Again, in other cases, the attack is local, and its nature pretty evident; from the beginning there is pain in one or other iliac region, tenderness, and shortly after, tumefaction, with fever.

d. Lastly, the affection may at first assume the character of a more general affection of the peritoneum, the pain extending over the abdomen, occurring mainly in paroxysms, with tenderness on pressure, and fever, but by and by, the general tenderness and extended pain subsides, and becomes localized, by which the character of the attack is determined.

5. *Symptoms.*—Having briefly alluded to the various modes in which the disease commences, I prefer taking the symptoms in the order of their importance and prevalence, rather than in that of succession.

* "On more important Diseases of Women," p. 25.

† Mauriceau, vol. ii. p. 249.

a. The presence of tumefaction, or of a distinct tumour, is invariable; it occurs in all cases, and characterizes the disease. It may be found completely above Poupart's ligament, above the linea ilio-pectinea, sometimes occupying one iliac fossa entirely, and even extending upwards nearly to the umbilicus, and forwards to the linea alba.

Or it may be situated more deeply in the pelvis, just reaching to Poupart's ligament, protruding the groin, and from its fixedness giving the impression of its being firmly connected with these parts. In the former case the tumour is larger, more defined, and far more moveable: in the latter it is rather undefined, immoveable, and more painful. In both it is equally hard, in fact as hard as stone, until suppuration commences, and equally tender on pressure. If a vaginal examination be made, in the former case, we do not always discover any change; the vagina may be cool, no tumefaction may be detected, and movement of the uterus may occasion but little pain. But in the latter cases, and also in the former when the inflammation is much diffused, the vagina is hot, somewhat tender; and at one of its sides, or at its upper part, in the "cul de sac" on one side of the cervix uteri, a hard, painful swelling is observed, evidently connected with the tumour in the groin, and in these cases the uterus cannot be moved without acute pain.

b. Although it may be developed at different periods, yet sooner or later, pain is an accompaniment of the disease. It maintains, as it were, its seat in the tumour, from whence stings of pain radiate in all directions. When the tumour is high, that is, above the brim of the pelvis, the pain is more limited to the tumour: when situated in the pelvis and groin, it extends across that cavity, down to the anus, to the back, and down the thigh. In these cases it is almost always difficult, in some cases quite impossible, to straighten the thigh, so as to stand upright. Walking, too, is both difficult and painful.

c. In these latter cases also, when the tumour occupies a portion of the pelvic cavity, we often find the patient distressed by tenesmus, and a desire to make water frequently the consequence, probably, of an extension of the irritation to the bladder and rectum. Occasionally, when the tumour is large, it offers a mechanical improvement to the functions of these viscera, and the patient may suffer from dysuria, or be unable to evacuate the intestinal canal.

d. The amount of fever, as well as the time of its setting in, varies. In some cases it precedes or accompanies the first local symptoms: in others it supervenes after the tumour has been detected some time. In a few cases it is almost confined to the evening, and during the process of suppuration there are, in almost all cases, evening exacerbations.

The pulse ranges from 90 to 110; the tongue is loaded, the skin hot, the thirst considerable, and the urine high coloured. The appetite is always bad.

These symptoms are somewhat mitigated, or at least the patient suffers less in cases not connected with parturition.

6. *Terminations.*—After being fully developed, and running on even for a considerable time, the disease may terminate:

A. *In resolution.*—This most frequently occurs with cases in which the tumour is above the brim, and limited in extent; and in such we find the pain diminishing, and ultimately ceasing, the tumour first becoming less tender, then less in size, until at length it disappears. This process will occupy from one to three months.

B. *In abscess.*—When suppuration takes place we can generally feel a degree of softening, with an obscure sense of fluctuation in the tumour either externally or internally; the patient complains of more throbbing, and occasionally of rigors, and by degrees (if not anticipated) the coverings are thinned, and the matter may escape—

a. Externally, through the abdominal parietes covering the tumour.

b. Into the peritoneum, where it gives rise to peritonitis, always alarming, but not always fatal.

c. Into the vagina, through which the matter escapes

d. Into the bladder* or intestinal canal, and especially the rectom,† with evacuation of matter per stool.

e. Into the surrounding cellular tissue, where it may burrow until it finds an outlet.

The matter may be evacuated by any of these "routes;" and if the opening be sufficiently large, the sac may be emptied and the abscess fill up and heal. But if the opening be small, the discharge may continue for an indefinite length of time, the opening remaining fistulous, and the cure being proportionably difficult.

f. Lastly. The extent of the disease, or the secondary affections caused by it, may prove fatal after an indefinite time.

7. *Diagnosis.*—A good deal of light will be thrown upon the diagnosis, when the disease occurs within a reasonable time after parturition, and especially when the patient has suffered from abdominal pain: in such cases if we discover a tumour in one of the iliac fossæ, with tenderness and pain, we shall have adequate grounds for diagnosticating this affection.

If, however, the attack occur independently of child-bearing, or at a considerable interval afterwards, there may be difficulty in distinguishing between it and some of the chronic organic diseases of the ovary, especially when the tumour is above the pelvic brim: our safest guide, probably, will be the amount of pain and constitutional disturbance, which is much greater in the disease I have been describing.

I have known this affection mistaken for sciatica; and when the tumefaction is mainly confined to the pelvis, and pressure is made upon the nerves issuing from the cavity, the pain may be limited to the track of the nerves, so as to deceive any but a careful observer. However, a minute investigation will probably enable us to trace the pain into the pelvis, and then an external and especially an internal examination will at once reveal the cause of the pain.

The flexion of the thigh, which alone might also mislead, will of itself lead to an examination of the groin, and so to the detection of the tumour.

8. *Treatment.*—The indications of cure are 1, to procure resolution of the tumefaction; or 2, to promote suppuration and evacuation of the matter.

1. If we are called in at an early period of the attack, it is often possible to arrest its progress, as has been well remarked by Dr. Doherty; nay, even where the disease has lasted some time, as in the cases I have quoted from Puzos, it is in some cases quite possible to procure resolution. For this purpose Mauriceau,‡ and the author just named, advises repeated venesection, with purgatives, alteratives, absorbents, &c. I believe that the repeated application of leeches will be found more effectual at less expense of strength. A dozen should be applied over the tumour, followed by bran poultices, and repeated if necessary, i. e. if the pain and throbbing be not relieved. If we succeed in arresting the progress of the inflammation, a succession of small blisters will be of great use. Fomentations, and an occasional hip-bath, also afford great relief to the patient; but still more comfort is derived from vaginal injections of warm water twice a day.

Internally, we may exhibit mercury in small doses, perhaps even so far as to affect the gums, and an occasional purgative; but I confess I am not convinced that brisk purgation is beneficial. In some cases I am certain that it increases the pain. If the pain prevent sleep an opiate may be given.

When the disease shows signs of yielding, I have seen benefit derived from an application of the empl. hydrargyri. The diet should be bland and nutritious, but unstimulating.

2. If, however, notwithstanding the prompt and sedulous use of the means I have indicated, the disease should not yield, we may be sure that suppuration

* Boivin and Dugè's "Diseases of the Uterus," page 578. Trans.

† Ibid.

‡ Mauriceau, vol. ii. p. 248.

will take place; and onr object then will be to promote this by fomentations and poultices constantly applied.

The formation of matter will sometimes be indicated by rigors, but in many cases it is by the touch only that we can recognize this occurrence. I cannot too strongly impress upon you the advantage of making an opening into the abcess when it is possible, and so deciding the course which the matter is to take, instead of leaving it to hurrow and make an upening in some dangerous situation.

The best situation for the opening is through the abdominal parietes; the next, through the vagina. If from the high situation and mobility of the tumour, we fear that, when opened, the matter may escape into the peritoneal cavity, we might adopt the plan so successfully practised in abscess of the liver by Dr. Graves, and cut down to, but not through, the parietal peritoneum, and then apply poultices, with little doubt but that the matter will ultimately make its appearance through the wound.

Should the abscess open spontaneously, we must counteract as well as possible any unpleasant consequences which may result; but whether opened spontaneously or by the knife we must endeavour to empty the sac, and to secure a free exit for the matter as it is secreted, by which means we shall avoid the prolongation of the disease, and all the distress of n fistulous communication.

When the matter has been fairly evacuated, the diet must be generous, and a full share of wine or porter allowed.

MEDICAL JURISPRUDENCE AND TOXICOLOGY.

46. *Hydrostatic Test* —A woman was confined in the Hospital Necker. Paris, of a female child, and died a few days after, of phthisis. The child was small and weak, the pulse was imperceptible in either the radial or brachial arteries, and the beatings of the heart were inaudible. Respiration partook of the languor which marked the other functions, the inspirations were twenty-eight in a minute, without any very decided heaving or falling of the abdomen, and expirations yielding no audible sound. Yet, on auscultation, a distinct crepitant rale was heard both before and behind, and at the base or summit of the chest. The child progressively sank, and died in eighteen hours.

On examination. the digestive organs were found to be healthy, and the large intestines contained a large quantity of meconium; the thymus body was very small; the ductus arteriosus and venosus and the inter-auricular foramen remained open. The lungs, instead of occupying their usual place, were small, and confined to the posterior part of the chest; and when removed from the thoracic cavity, together with the heart, and plunged into water, *the whole immediately sunk to the bottom.* The lungs were of the colour of port wine lees, being hepatized, except in a few places, where their cellular structure was more apparent. On cutting into them, a sensation like that of cutting through liver was experienced, and no blood. fluid, or froth, escaped. One lobe, cut through in many places, and immersed under water, gave egress to only five or six small bubbles of air, and another lobe artificially inflated, suffered itself indeed to be penetrated by air, and showed a curiously mottled aspect, and a rosy tinge; but as soon as the bellows was removed, it returned to its previous condition, and *sank in water, as it had done before.—Gazette des Hôpitaux.*

This case has been cited as affecting the value of the hydrostatic test. It is strange that those who pretend to knowledge in the matter are not aware that precisely similar cases have been noticed by Haller, Brendel, and Billard, as *exceptions to the general rule*, and are thus acknowledged. T. R. B.

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47. *New Test for Corrosive Sublimate*, by Dr. Frampton.—Dr. F. states that he was led to this method, by reflecting on the strong affinity of metallic silver both for metallic mercury and for chlorine. He rubbed a grain of corrosive sublimate with several grains of pure metallic silver in powder; the mixture